RECEIVED 11/30/07

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

On October 2, 2007, a recertification survey in conjunction with a complaint investigation was conducted through October 5, 2007, utilizing the full survey process. A random sample of five was selected from a residential population of two male and six females clients with a diagnosis of profound mental retardation.

The findings of the survey and investigation were based on observation at the group home and three day programs, interviews with group home staff, day placement staff, the nutritionist, the administrator, the Qualified Mental retardation Professional, review of medical and administrative records including the unusual incident reports.

On September 28, 2007, the State Agency received an e-mail from the court monitor's office that described client's care and treatment concerns. The compliant alleged that there were persistent pattern of problems as detailed below:

1. "Upon the individuals' return home from their day program, water/fluids were not given or offered a second time to individuals who initially resisted/refused the water/fluids. In addition, individuals were not toileted or changed upon their return home."

2. "Throughout the observation period, one of the four staff members on duty spent the majority of the time preparing dinner while the other three staff members sporadically interacted with the individuals."

3. "Class members' logs of community outings revealed that they had participated in only two

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Branch	DRS	11/9/07

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 1 outings during the period of September 1 - 19, 2007 - park and church. There was no evidence that any community outings occurred in August 2007." 4. "As noted in the prior reviews, direct care staff members, as well as the nurse on duty at the time of the review, lacked basic knowledge of the class members' current health care problems and needs." 5. "As noted in the prior reviews, class members' positioning logs indicated that they spend the majority of their day sitting in their wheelchairs." [Substantiated and Condition Level Deficiencies Cited] 6. "On August 24, 2007, when Client #2 returned from her day program, she was "found" with a laceration on the right side of her forehead. Client #2 was taken to the emergency room, treated, and released with staple(s) in her forehead, which were to be removed in seven days. This serious reportable incident was not reported to the court monitor's office." 7. "There was no evidence that Client #2's neurologist's 8/2/07 recommendation to obtain monthly Dilantin and Phenobarbital levels for Client #2 was implemented." [Substantiated and Standard - Level Deficiencies Cited] 8. "Since March 2007, Client #1 has lost 13 pounds, which is over 10% of her body weight. There was no evidence that Ms. Client #1's intake is being closely monitored and recorded or that there was follow-up to her incomplete study/pelvic sonogram, which took place on June 29, 2007." [Partially Substantiated - Standard Level	W 000		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 2 Deficiencies Cited] 9. "There was no evidence that Client #1's dietician had conducted a review and assessment of the changes in Client #1's nutrition status and her weight loss. The most recent nutrition assessment filed in Client #1's record was dated 8/13/06, and it was no longer a current or accurate portrayal of the client's nutrition/weight status." [Substantiated - Standard Level Deficiencies Cited] 10. "In addition, although Client #1's physician, registered nurse, and agency Director of Nursing were notified of Client #1's abnormal blood-glucose levels of 39 (obtained on 8/21/07) and 54 (obtained on 8/27/07) , each of which represented a marked changed from her blood-glucose level of 98 in April 2007, there was no evidence any follow-up to these abnormalities." 11. "Since March 2007, Client #5 has also sustained an unexplained weight loss of 8.5 pounds. As noted in the prior review, neither Client #5's nurses' nor her QMRP's reports addressed the client's weight loss." [Particially Substantiated - Standard Level Deficiencies Cited] 12. "The numerous copies of the class members' Health Risk Management Plans, which were filed across the class members' Medical, ISP, and Program records, were not complete, current, or accurate."	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include	W 100	W100	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4615 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 100	Continued From page 3 services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that each client received continuous active treatment services. [See W195]	W 100		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility, (See W104) failed to ensure that all personnel making entries into the clients records wrote legibly, dated and signed each entry (See W114) and failed to ensure nutritional oversight on the facility (See W( )	W 102	W102 • At time of hire all ~~staff~~ receive initial training and review making entries into client records which are legible dated and signed. • At least annually thereafter all staff received additional training on documentation. • Also reference response to W114 and W(	10.26.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AN[illegible] AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 102	Continued From page 4 The systemic effect of these practices results in the failure of the governing body to ensure continuous active treatment services for its clients. (See W195)	W 102	Reference response	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews with staff, and the review of records, the facility's governing body provided general operating directions over the facility except in the following areas: The findings include: 1. The facility failed to develop and implement its established policies to ensure the health and safety of the clients. (See W149) 2. The facility failed to ensure that clients received a continuous active treatment program for one of the four clients in the sample in accordance with recommendations made by the interdisciplinary team (IDT) for two of the four clients included in the sample. (See W196) 3. The facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and provided (See W436)	W 104	Reference response to W149 Reference response to W196 Reference response to W436	11.14.07 ongoing
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114	W114	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 114	Continued From page 5 This STANDARD is not met as evidenced by: 0.Based on interview and record review, the facility failed to ensure that all personnel making entries into the clients records were dated and signed each entry for two of the four clients in the sample. (Clients #1 and #4) The findings include: 1. The facility's primary care physician failed to date his entry for Client #1's abnormal laboratory profiles. Review of the complaint received on September 28, 2007, revealed that Client #1 had blood drawn on August 18 and 24, 2007. The blood glucose results were 39 and 54 respectively. These results were noted as being below the normal range documented as 74 - 105. Review of the laboratory report dated August 18, 2007 revealed that the Primary Care Physician reviewed the results', however he did not date his entry it could not be determined if the results were reviewed timely. 2. The facility's Registered Nurse (RN) failed to sign Client #4's quarterly reviews. Interview with the facility's Licensed Practical Nurse (LPN) on October 4, 2007 at approximately 3:00 PM revealed that the one of two RN completes quarterly nursing exams. Review of the Client #4's medical record revealed that a nursing assessment was completed in March 2007, with quarterly follow ups (June 2007, September 2007). However, the quarterly reviews were not signed to indicated who had	W 114	W114 This Standard will be met as Evidenced by: (1) Primary Care Physician has dated entry. RN will review deficiency w/ PCP to ensure that future entries are dated.	10.26.07 ongoing
			(2) RN has reviewed and signed all quarterly reports. RN will continue to complete quarterly nursing exams and sign upon completion	10.26.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 114	Continued From page 6 completed the quarterly reviews.	W 114		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that outside services met the needs for one of the four clients in the sample (Client #1) The finding includes: On October 2, 2007 at 7:20 AM, Client #1 was observed using an angled spoon during her breakfast. On October 2, 2007 at the day program, the client was observed eating her lunch. The client had an adaptive plate and built up handled spoon. At the dinner meal on the same day the client utilized an angled spoon for eating. Record reveiw revealed that the client was prescribed an angled spoon during meals. The day program observation was brought to the attention of the Qualified Mental Retardation Professional (QMRP), who was not aware that the day program was not using the recommended adaptive feeding equipment at her day program.	W 120	W120 This Standard will be met as evidenced by; • QMRP will provide day program with adaptive equipment. (angled spoon) • QMRP will visit day program discuss adaptive equipment needs and provide additional training as needed.	11-14-07 ongoing
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124	W124	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of the four clients in the sample. (Client #4) The findings includes: During the entrance conference on October 2, 2007 at 9:40 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #4 had a legal guardian and Behavior Support Plan (BSP) to address his maladaptive behaviors of self injurious behaviors, aggression, stripping and masturbation. Review of the BSP dated September 28, 2006 revealed that restrictive measures were required as part of the techniques used to manage the behaviors. On October 4, 2007 at 9:30 AM, review of Client #4's record failed reflect written informed consent for the use of the BSP. Continued review of Client #4's records revealed a psychological assessment dated March 21, 2007. The assessment documented that the client had profound mental retardation and was not competent to make independent decisions regarding health, medical and financial decisions. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using these restrictive measures, or his right to refuse treatment had been explained to the client	W 124	W124 This Standard will be met as evidenced by: • QMRP will obtain written informed consent for client #4. • Also reference response to W263.	11.16.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 8 and/or legal sanction representative. [See W263]	W 124		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients had clothing that was the appropriate size for one of the four clients included in the sample. (Client #1) The finding includes: On October 2, 2007 Client #1 shirt appeared too big as the arms of the shirt hung over her hands. Interview with the staff acknowledged that the client's clothes were two large and indicated that she had recent weight loss. Interview with the Qualified Mental Retardation Professional (QMRP) also acknowledged that the client has loss weight and that the day program had been concerned with her clothes being too big.	W 137	W137 This Standard will be met as evidenced by: • New clothing items have been purchased for client #1. • Style of clothing worn by client #1 on 10/2/07 was designed with long sleeves, to give the appearance of extended sleeves. W140	10.31.07 ongoing
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide receipts for withdrawals from the clients personal funds account for one of	W 140	This Standard will be met as evidenced by:	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 140	Continued From page 9 the four clients in the sample. (Client #2) The finding includes: Review of Client #2's financial was conducted on October 2, 2007 for Client #2. The review of the bank statements from November 2006 through August 2007 revealed a withdrawal on November 10, 2007 in the amount of $500.00. Interview with the Qualified Mental Retardation Professional (QMRP) on October 3, 2007 at approximately 11:00 AM indicated that the money withdrawn was spent on a recliner chair. There were no receipts however to determine how or when the monies were spent.	W 140	The Standard will be met as evidenced by: • The QMRP will provide a receipt for the recliner chair. • In the event a receipt for purchase of a recliner chair cannot be located and/or duplicated, funds will be reimbursed to client #2's account. • The Home Manager will ensure that all receipts are filed on a monthly basis and the information is available for review.	10.24.07 ongoing
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents or guardians of significant incidents for one of the eight clients residing in the facility. (Clients #2) The findings include: Review of the facility's unusual incident reports and investigations on October 2, 2007 at approximately 8:20 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents:	W 148	W148 The Standard will be met as evidenced by: • QMRP will notify family members immediately of all significant incidents. • QMRP will document person/s notified, and the date/time of notification/s on the incident report form.	10.24.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	Continued From page 10 a. On April 17, 2007, staff discovered Client #2 with a three centimeter discoloration on her left thigh. b. On August 24, 200, Staff discovered a laceration to Client #2's head for which she was treated in the emergency room.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to establish a policy on injuries of unknown origin. The finding includes: [Cross Refer to W153 and W154] The facility failed to establish a policy and procedure on reporting and investigating injuries of unknown origin. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at approximately 2:00 PM revealed that staff were required to write an incident report, notify appropriate management, family members, guardians, attorneys and all other governmental agencies; however these procedures were not written in the Incident Management policy.	W 149	W149 This Standard will be met as evidenced by: • Reference response to W153 and W154. • Incident Management policy will be reviewed/revised as needed. • QMRP will provide additional staff training as needed to further ensure compliance with this standard.	11.18.07 ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 11 immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) four of the eight clients residing in the facility. (Client's #2, #3, #6 and #7). The findings include: Review of the incident reports on October 2, 2007 beginning at 8:20 AM revealed the following incidents had not been reported to the State Agency as required: a. On April 17, 2007, staff discovered Client #2 with a three centimeter discoloration on her left thigh. b. On September 11, 2007, the staff discovered a "mark" on Client #3's left back arm. c. On July 16, 2007, the staff discovered a scratch on Client #3's right back leg. d. On July 9, 2007, the staff discovered an abrasion on Client #3's left lower leg. e. On June 24, 2007, the staff discovered a bruise on Client #6's right elbow. f. On June 18, 2007, the staff discovered a blister	W 153	W153 This Standard will be met as evidenced by: • QMRP will report all unusual incidents, including injuries of unknown origin to the administrator and other officials according to district law. • Incident Manager will review incident reporting procedures on a routine basis and provide appropriate follow-up actions as needed to further ensure compliance with this standard. • Documentation of all notifications will be maintained on file for review.	11.16.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 12 on Client #7's right knee.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to consistently document thorough investigation of all injuries of unknown origin, for three of the eight clients that reside in the facility. (Client's #3, #6, and #7) The findings include: Review of the incident reports on October 2, 2007, revealed the following incidents reflecting injuries of unknown origin were not investigated. a. On April 17, 2007, staff discovered Client #2 with a three centimeter discoloration on her left thigh. b. On September 11, 2007, the staff discovered a "mark" on Client #3's left back arm. c. On July 16, 2007, the staff discovered a scratch on Client #3's right back leg. d. On July 9, 2007, the staff discovered an abrasion on Client #3's left lower leg. e. On June 24, 2007, the staff discovered a bruise on Client #6's right elbow. f. On June 18, 2007, the staff discovered a blister on Client #7's right knee.	W 154	W154 This Standard will be met as evidenced by: • QMRP received disciplinary action for failing to complete incident investigations in a timely manner. • Incident investigations will be completed for each of the listed incidents. • Information will be made available for review.	11.16.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment programs . The findings include: 1. The facility's QMRP failed to ensure that outside services met the needs of the clients. [See W120] 2. The facility's QMRP to ensure receipts for withdrawals from the clients personal funds account were available for review. [See W140] 3. The facility's QMRP failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) [See W153] 4. The facility's QMRP failed to investigation of all injuries of unknown origin. [See W154] 5. The facility's QMRP failed to ensure that clients received a continuous active treatment program for one of the four clients in the sample in accordance with recommendations made by the interdisciplinary team (IDT). [See W196]	W 159	W159 This Standard will be met as evidenced by: 1. Reference response to W120. 2. Reference response to W140. 3. Reference response to 22 DCMR, Chapter 35, Section 3519.10. Also reference response to W153. 4. Reference response to W154. 5. Reference response to W196. 6. Reference response to W210. 7. Reference response to W217. 8. Reference response to W220. 9. Reference response to W241. 10. Reference response to W242. 11. Reference response to W247. 12. Reference response to W249. 13. Reference response to W250.	11-23-07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID1	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 14 6. The facility's QMRP failed to ensure that assessments had been completed within 30 days after admission by the interdisciplinary team. [See W210] 7. The facility's QMRP failed to ensure that a nutritional assessment was completed. [See W217] 8. The facility's QMRP failed to ensure that a speech language assessment was coordinated to determine the client's communication needs. [See W220] 9. The facility's QMRP failed to provide behavior strategies to staff. [See W241] 10. The facility's QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting. [See W242] 11. The facility's QMRP failed to ensure that each client was provided an opportunity for choice. [See W247] 12. The facility's QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their Individual Program Plans. [See W249] 13. The facility's QMRP failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program. [See W250] 14. The facility's QMRP failed to collected data that was reflective of actual client's performance.	W 159	W159, Continued... 14. Reference response to W252. 15. Reference response to W260. 16. Reference response to W436. 17. Reference response to W137.	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 15 [See W252] 15. The facility's QMRP failed to make revisions or to justify the repetition of the objectives from the previous year. [See W260] 16. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and provided. [See W436] 17. The facility's QMRP failed to ensure Clients had the appropriate size clothing. [See W137]	W 159		
W 170	483.430(b)(5) PROFESSIONAL PROGRAM SERVICES Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure that the Professional program staff was licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. The finding includes: Review of the records revealed the following professional staff who lacked evidence of a current license: Two Social Workers, the Physical Therapist and two Licensed Practical Nurses.	W 170	W170 This Standard will be met as evidenced by: • Administrative Assistant will obtain all required licenses for two Social Workers and the Physical Therapist. • The Human Resource department will obtain two LPN licenses to ensure compliance with this standard. • Both Administrative Assistant and the Human Resources Department will continue to monitor and track expiration dates of required licenses/certifications of professional staff to further ensure compliance with this standard.	11-16-07 ongoing
W 180	483.430(b)(5)(x) PROFESSIONAL PROGRAM SERVICES	W 180		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 180	Continued From page 16 To be designated as a human services professional, an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology). This STANDARD is not met as evidenced by: Based on review of personnel records, there was no evidence that the facility had hired a Qualified Mental Retardation Professional (QMRP) in accordance with the federal regulations. The finding includes: Interview with the QMRP on October 2, 2007 revealed that she had been working for many years in coordinating and monitoring services to persons with mental retardation. Review of the QMRP's educational credentials, however, indicated that she does not hold at a least a bachelor's degree in an area designated as a human services professional category or meet the educational qualifications as specified by federal regulations. (See W159)	W 180	W180 This Standard will be met as evidenced by: Reference response to W159.	11-23-07 ongoing
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Behavior Support Plan (BSP) for one of the five clients in the sample. (Client #4)	W 193	This Standard will be met as evidenced by: • Client #4's personal skills will be assessed/evaluated. • Activity schedule for client # 4 will be reviewed/modified as needed.	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 17 The finding includes: The facility failed to implement Client #4's BSP as written. [Also See W196] On October 3, 2007 at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors during lunch. During the behavior , a direct care staff intervened by stating, "Oh, no we won't have that". The client momentarily stopped and proceeded to face slap again. There was no intervention from the staff. According to the BSP the strategies reviewed on October 4, 2007 at 2:00 PM, the staff should ask the client to stop, if not, then the staff should move the client's hand down from his face and continue with proactive strategies.	W 193	• QMRP will conduct additional training to include but not limited to; adherence to mealtime protocol, implementation activity schedule, interaction and active participation of individuals in their daily routines, behavior support plans & positioning. (2) Reference response to W196 #1, • QMRP will develop program objective to enhance client #4's skills.	11-20-07 ongoing
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment services (See W196 and W249); the facility failed to ensure that assessments had been completed within 30 days after admission by the interdisciplinary team (See W210); the facility failed to provide a speech language assessment to determine the client's communication needs (See W220); the facility failed to provide behavior strategies available to staff (See W241); failed to ensure that clients' individual program plans (IPP) included training in personal skills (See W242); the facility failed to ensure clients were provided	W 195	W195 This CONDITION will be met as evidenced by: The facility will ensure that active treatment services and requirements are met as evidenced by: Reference responses to W196, W249, W210, W220, W241, W242, W247, W250, W252, W260, and W436.	11-20-07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 195	Continued From page 18 with opportunities for choice and self-management(See W247); the facility failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program (See W250); failed to ensure data relative to the accomplishment of the criteria specified in each client's IPP objectives were documented in measurable terms(See W252); the interdisciplinary team (IDT) failed to make revisions or to justify the repetition of the objectives from the previous year (See W260); and the facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and provided (See W436) The effects of these systemic practices results in the failure of the facility to adequately provide active treatment services.	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure that	W 196		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 19 clients received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT) for two of the four clients included in the sample. (Clients #3 and #4) The findings include: 1. On October 3, 2007 Client #4's home activities from 8:00 AM to 1:30 PM were observed and revealed the following: a) Upon the surveyors arrived to the home at 8:00 AM Client #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. b) At appoximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitative activities. c) At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. d) During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support	W 196	W196 This Standard will be met as evidenced by: • Client #4's personal skills will be assessed/evaluated. • Program objectives will be established as needed. • The Activity Schedule for client #4 will be reviewed/modified as needed. • QMRP will conduct additional training as needed to include but not limited to; mealtime protocols, implementation of activity schedules, client interactions and active participation of individuals in their daily routines, behavior support plans and positioning. • Routine file reviews will be conducted to further ensure compliance with this standard.	11-13-07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 20 Plan, reviewed on October 3, 2007, required the staff to ask the client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. e) After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride. 2. Interview with staff on October 2, 2007 revealed that Client #4 dependents on staff for basic personal needs On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care skills had been identified/assessed. 3. Review of Client #4's IPP revealed that recommended training programs were not consistently implemented as evidenced below: Review of the Client #4's IPP revealed objectives to enhance sensory awareness, to improve lower range of motion and strengthen lower extremities, and to improve ambulation and auditory skills. At no time during the observations did the staff direct encourage, the client to participate in any of the aforementioned program	W 196	W196. continued. (2) Reference response to W196 #1. • QMRP will develop program objectives as needed to enhance client #4's skills. (3) QMRP will conduct additional training on implementation and documentation. QMRP / Home Manager will monitor implementation and documentation of program objectives and provide	11.13.07 ongang

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 21 objectives as evidenced below: a) Three times per week, the client will feel/manipulate items in his feel box for three minutes with hand over hand assistance for six consecutive months by 10/07. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007 revealed that there was no box available with such items. Review of the data, however, revealed that the program was being implemented and that the client had acheived the required objective, since April. The facility QMRP could not explain how the program was being implemented without the box. b) [The client] will dance with staff for three minutes two times per day 100% accuracy for six months. Although the data collection refect that this program had been implemented in the past, there was no evidence that the program had been implemented during the survey period. Additionally, the data collected did not measure the progress of the objective. [Also See W252] d) [The client] will ambulate one trip around the interior of the home two times a day with moderate physical assistance of one person at 100% accuracy for six months". Although the October 2007 data collection refected that this program was being implemented one time a day, this program was not observed during the survey period.	W 196	196. continued... • feedback and direction as needed. • Also reference response to W252. • QMRP will review and/or revise program objectives as needed. • QMRP will ensure that program objective is measureable, also reference W252. • QMRP will coordinate re-assessment by Physical Therapist for client #4.	11.14.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 22 2. The facility failed to implement Client #3's program objectives. a) Interview with the QMRP on October 2, 2007 at 9:40 AM indicated the Client #3 was admitted to the facility on March 26, 2007. During evening observation on October 2, 2007 from 3:45 through 6:55 PM, Client #3 was not engaged in any formal or informal active treatment programs. At 3:30 PM, the client arrived home from his day program and shortly thereafter, at approximately 3:45 PM, was taken to his bedroom. He was observed to lie in bed until 6:55 PM. The client was observed to need total assistance in transferring from his wheelchair to and from bed. At 6:55 PM, the client was propelled into the living room and positioned in front of the television, where he remained until he received his G-tub feeding at 8:00 PM. There was no observation that the staff presented the client with a choice of leisure time activities or engaged the client in any other activty. b) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will sit on the edge of the bed for two minutes three times a day without assistance for three months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were documenting only twice a day. c) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will tolerate	W 196	W196, continued • QMRP will review and/or revise program objective as needed. • QMRP will provide staff training on all active treatment programs for Client #3. • QMRP will modify data collection to include twice a day.	11.14.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 23 stretching to his lower extremities daily for two minutes each stretch for six months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were not documenting the number of minutes. d) Review of client's IPP dated April 25, 2007 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the client] will make a selection of what clothes to wear daily in 80% of the trials presented for six consecutive months by April 2008." On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Client #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected by the staff for the client to wear on the next day. There was no evidence that the facility encourage the client to participate in this task. 3. During the evening meal observation on October 2, 2007, Client #1 ate her meal with minimal to no assistance from staff. Upon the completion of the meal, the staff who was assisting the client with her meal, passed the dish and eating utensils to another staff person who was located in the kitchen. Review of the clients IPP objective on October 4, 2007, revealed that the client had a goal to increase her activities of daily living skills. To accomplish this goal, the client was required ". . . after dinner meal, given physical assistance, [Client Name] will remove her plate to the kitchen on 100% of the trials presented for six consecutive months." On October 2, 2007, Client #1 was not afforded an opportunity to participate in this IPP goal.	W 196	• QMRP will provide additional staff training on choice making.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that assessments had been completed within 30 days after admission by the interdisciplinary team for one of the four clients in the sample. (Client #4) The finding includes: [Cross Reference W196] During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 PM revealed that Client #4 was admitted into the facility on March 1, 2007. On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care skills had been identified/assessed.	W 210	W210 • Cross reference response to W196 • QMRP will ensure that client #4's personal care skills will be addressed. W220	11-13-07 ongoing
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN	W 220		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 220	Continued From page 25 The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a speech language assessment to determine the client's communication needs, for one of the four clients in the sample. (Client #4). The finding includes: Observation during the survey from October 2, 2007 through October 5, 2007 revealed that Client #4 was non-verbal. On October 2, 2007 during breakfast the staff was observed feeding the client his meal. The staff would asked the client before scooping the food, which food item from his plate he wanted next. The client did not respond verbally, however, he would turn his head away from the utensil to indicate that he did not want to eat the spoon of food. He was also observed to intentionally turning over his cup of water to indicated that he did not want water. The staff acknowledge that the client communicates his dislike for water by spilling it. The staff indicated that there were no formal means of communicating with the client. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007 at approximately 11:00 AM indicated that the client's 30-day review on March 28, 2007 revealed that the Interdisciplinary Team (IDT) recommended to continue with all previous program objectives. Review of the records revealed that the speech pathologist noted, that	W 220	This Standard will be met as evidenced by;	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 220	Continued From page 26 "a report" would be completed within 30 days. Further review of the records revealed that an evaluation by the speech therapist was completed on June 28, 2007. The evaluation however, did not identify any training needs or skill deficits. It should be noted that the client was ordered and served a pureed diet. The speech assessment did not address the reasons for the pureed texture diet. At the time of the survey, the facility failed to ensure Client #4 received a current Speech Therapy assessment that documented the client's current functioning level.	W 220	• QMRP will coordinate and schedule a Speech Therapy assessment for client #4 to include but not limited to diet and training needs/ communication abilities as well as communication skill deficits.	11.20.07 ongoing
W 224	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess adaptive behaviors and/or independent living skills, for one of the five clients in the sample. (Client #5) The finding includes: On October 2, 2007, at 6:00 PM Client #5 was observed during meal time. The client, with an adaptive spoon, ate a pureed dinner using a high sided plate that had an attached plate guard. During the process of eating, however, there was spillage. As the client brought the loaded spoon to her mouth she turned the spoon causing the food to spill back into the plate. After the facility's nurse observed the client's eating techniques, the	W 224	W224 This Standard will be met as evidenced by: • QMRP will follow-up with the occupational and speech therapist to further evaluate adaptive equipment needs for client # 5.	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 30 consecutive months by April 2008." 2. The facility failed to provide Client #5 an opportunity to choose to have dressing on her salad. On October 5, 2007 at 6:10 PM Client #5 was observed eating a pureed meal for dinner. The dietary order required that the client be served a salad for lunch and dinner. The staff was observed pureeing the lettuce and served it to the client. When asked if the client had a preference in salad dressings, the staff stated "I don't think she likes dressing." There was no attempt by staff to offer the client a dressing for her salad.	W 247	• Additional staff training will be conducted on decisum and choice making abilities of client #5.	11.20.07 ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their Individual Program Plans (IPPs) for three of four clients included in the sample. (Clients #1, #3 and #4) The findings include: On October 3, 2007 Client #4's home activities	W 249	W249 This Standard will be met as evidenced by: • Reference response to W102, W120, W124, W193 and 137, W195, W224 W241 W242 and W247. 11.20.07 ongoing • QMRP will purchase equipment and/or devices, materials and supplies as needed to further ensure compliance with this standard.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 224	Continued From page 27 nurse acknowledged that the client's adaptive equipment and/or feeding techniques needed to be re-assessed.	W 224	W224 • QMRP will coordinate additional training as needed.	
W 241	483.440(c)(6)(ii) INDIVIDUAL PROGRAM PLAN The individual program plan must identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to provide behavior strategies available to staff for one of the four clients in the sample. (Client #3) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Client #3 had a behavior support plan that addressed maladaptive behaviors. The plan however was discontinue due to the discontinuation of the client psychotropic medication regime on April 23, 2007. Further interview with QMRP and record review revealed that behavior guidelines were designed and required to be implemented as needed. The guidelines, however, were not available in the client's program book for staff review and implementation. Interview with the QMRP on October 3, 2007 at approximately 12:45 PM revealed that the behavior guidelines could not be located.	W 241	W241 This Standard will be met as evidenced by • Behavior guidelines have been implemented for client#3, 11.14.07 • Behavior guidelines have been filed and direct care/nurses staff assigned to the home received training on implementation of behavior strategies. ongoing • QMRP/Home Manager and Psychologist will continue to monitor status and make changes as needed.	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for	W 242	W242	

DEPARTMENT OF HEALTH

HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL STREET NE, 2ND FLOOR
WASHINGTON, DC 20002
FAX NOS. 202-442-9430 OR 202-442-9431

FACSIMILE TRANSMITTAL SHEET

TO: Mr. Ron Raghunandan	FROM: Ms. L. Wallace-202-442-4721 Admin. Support Specialist
COMPANY: Individual Development, Inc.	DATE: 10/22/2007
FAX NUMBER: 202-518-9685	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 202-518-0314	SENDER'S REFERENCE NUMBER:
RE: **ENFORCEMENT**	YOUR REFERENCE NUMBER:

☐ URGENT ☑ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

FOR THE FOLLOWING FACILITIES:

1. 4515 Edson Pl NE

Please be advised that typed document will follow.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 242	Continued From page 28 those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting for one of the four clients in the sample. (Client #3) The findings include: 1. During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 PM revealed that Client #4 was admitted into the facility on March 1, 2007. On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care	W 242	W242, continued... This Standard will be met as evidenced by: ■ QMRP will provide training programs as needed to enhance and increase client #3 & 4's personal skills. ■ QMRP will document attempts made toward client #4's ability to complete various skills. ■ Also, reference response to W196. ■ QMRP will conduct additional staff training as needed.	11.13.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 242	Continued From page 29 skills had been identified/assessed. 2. Review of Client #3's medical record revealed a dental consultation dated June 6, 2007. The consultation indicated that the client had heavy calculus deposits and poor oral hygiene. Review of the IPP dated April 25, 2007 failed to identified a toothbrushing program.	W 242	• QMRP will develop a toothbrushing program for client #3.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided an opportunity for clients choice for two of the four clients in the facility. (Clients #3 and #5) The findings includes: 1. The facility failed to ensure that Client #3 was provided an opportunity to participate in selecting his clothing. On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Client #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected by the staff for the client to wear on the next day. Review of client's IPP dated April 25, 2007 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the client] will make a selection of what clothes to wear daily in 80% of the trials presented for six	W 247	W247 This Standard will be met as evidenced by: • QMRP will continue to implement strategies and training for direct care staff which focus on importance of choice / decision making and self management. 11.14.07 ongoing • QMRP/Home Manager will monitor and provide oversight to further ensure that staff maintain attitudes and activities which promote individual choice.	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 31 from 8:00 AM to 1:30 PM were observed and revealed the following: a) Upon the surveyors arrived to the home at 8:00 AM Client #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. b) At appoximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitative activities. c) At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. d) During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. e) After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride.	W 249	W249, Continued... • QMRP/Home Manager will provide oversight and direction as needed to promote a consistent pattern of interactions and supports for each client. • QMRP will review all program objectives to ensure that interventions and documentation of program objectives is sufficient number and frequency to support achievement.	11.20.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 32 2. Interview with staff on October 2, 2007 revealed that Client #4 dependents on staff for basic personal needs On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care skills had been identified/assessed. 3. Review of Client #4's IPP revealed that recommended training programs were not consistently implemented as evidenced below: Review of the Client #4's IPP revealed objectives to enhance sensory awareness, to improve lower range of motion and strengthen lower extremities, and to improve ambulation and auditory skills. At no time during the observations did the staff direct encourage, the client to participate in any of the aforementioned program objectives as evidenced below: a) Three times per week, the client will feel/manipulate items in his feel box for three minutes with hand over hand assistance for six consecutive months by 10/07. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007	W 249		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 33 revealed that there was no box available with such items. Review of the data, however, revealed that the program was being implemented and that the client had acheived the required objective, since April. The facility QMRP could not explain how the program was being implemented without the box. b) [The client] will dance with staff for three minutes two times per day 100% accuracy for six months. Although the data collection refect that this program had been implemented in the past, there was no evidence that the program had been implemented during the survey period. Additionally, the data collected did not measure the progress of the objective. [Also See W252] d) [The client] will ambulate one trip around the interior of the home two times a day with moderate physical assistance of one person at 100% accuracy for six months". Although the October 2007 data collection refected that this program was being implemented one time a day, this program was not observed during the survey period. 2. The facility failed to implement Client #3's program objectives. a) Interview with the QMRP on October 2, 2007 at 9:40 AM indicated the Client #3 was admitted to the facility on March 26, 2007. During evening observation on October 2, 2007 from 3:45 through 6:55 PM, Client #3 was not	W 249		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 34 engaged in any formal or informal active treatment programs. At 3:30 PM, the client arrived home from his day program and shortly thereafter, at approximately 3:45 PM, was taken to his bedroom. He was observed to lie in bed until 6:55 PM. The client was observed to need total assistance in transferring from his wheelchair to and from bed. At 6:55 PM, the client was propelled into the living room and positioned in front of the television, where he remained until he received his G-tub feeding at 8:00 PM. There was no observation that the staff presented the client with a choice of leisure time activities or engaged the client in any other activty. b) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will sit on the edge of the bed for two minutes three times a day without assistance for three months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were documenting only twice a day. c) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will tolerate stretching to his lower extremities daily for two minutes each stretch for six months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were not documenting the number of minutes. d) Review of client's IPP dated April 25, 2007	W 249	W249	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007.
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 35 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the client] will make a selection of what clothes to wear daily in 80% of the trials presented for six consecutive months by April 2008." On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Client #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected by the staff for the client to wear on the next day. There was no evidence that the facility encourage the client to participate in this task. 3. During the evening meal observation on October 2, 2007, Client #1 ate her meal with minimal to no assistance from staff. Upon the completion of the meal, the staff who was assisting the client with her meal, passed the dish and eating utensils to another staff person who was located in the kitchen. Review of the clients IPP objective on October 4, 2007, revealed that the client had a goal to increase her activities of daily living skills. To accomplish this goal, the client was required ". . . after dinner meal, given physical assistance, [Client Name] will remove her plate to the kitchen on 100% of the trials presented for six consecutive months." On October 2, 2007, Client #1 was not afforded an opportunity to participate in this IPP goal.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250	W250	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 250	Continued From page 36 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program for one of the four clients in the sample. (Client #4) The finding includes: Upon the surveyors arrived to the home at 8:00 AM, Client #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. At approximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitation activities. At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. At 12:30 During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the	W 250	W250, continued... This Standard will be met as evidenced by: • QMRP will provide additional training as needed for all staff on individualized schedules, location of active treatment schedules as well as implementation of schedules. • QMRP will modify change schedules as needed to allow flexibility, personal preferences and normal routine. • QMRP will develop schedules as needed for client #4.	11.20.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 250	Continued From page 37 client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride. Interview with the direct care staff and review of the habilitation record revealed that the client had no activity schedule for that day, and no record of an alterative activity schedule.	W 250		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to collected data that was reflective of actual client's performance for two of the five clients included in the facility. (Clients #2, and #4) The findings include: 1. Observation at the group home on October 2, 2007, at approximately 7:20 PM, revealed staff getting Client #2 out of her wheelchair and repositioning the client on a couch located in the foyer of the building. On October 3, 2007, Client #2's repositioning log was review and it was determined that the staff failed to document that the client had been repositioned on the previous day. The oversight	W 252	W252 This Standard will be met as evidenced by: QMRP will provide additional staff training as needed to ensure that data is accurate and reflects the actual individual performance.	11.20.07 ongoing

****
*** RX REPORT ***
****

INCOMPLETE RECEPTION

TX/RX NO	5532	
CONNECTION TEL		
CONNECTION ID		
ST. TIME	11/09 08:17	
USAGE T	05'32	
PGS.	11	
RESULT	NG	##0106

DEPARTMENT OF HEALTH

HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL STREET NE, 2ND FLOOR
WASHINGTON, DC 20002
FAX NOS. 202-442-9430 OR 202-442-9431

FACSIMILE TRANSMITTAL SHEET

TO: Mr. Ron Raghunandan	FROM: Ms. L. Wallace-202-442-4721 Admin. Support Specialist
COMPANY: Individual Development, Inc.	DATE: 10/22/2007
FAX NUMBER: 202-518-9685	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 202-518-0314	SENDER'S REFERENCE NUMBER:
RE: **ENFORCEMENT**	YOUR REFERENCE NUMBER:

☐ URGENT ☑ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

FOR THE FOLLOWING FACILITIES:

1. 4515 Edson Pl NE

Please be advised that typed document will follow.

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID1	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 242	Continued From page 28 those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting for one of the four clients in the sample. (Client #3) The findings include: 1. During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 PM revealed that Client #4 was admitted into the facility on March 1, 2007. On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care	W 242	W242, continued... This Standard will be met as evidenced by: • QMRP will provide training programs as needed to enhance and increase client #3 & 4's personal skills. • QMRP will document attempts made toward client #4's ability to complete various skills. • Also, reference response to W196. • QMRP will conduct additional staff training as needed.	11.13.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 242	Continued From page 29 skills had been identified/assessed. 2. Review of Client #3's medical record revealed a dental consultation dated June 6, 2007. The consultation indicated that the client had heavy calculus deposits and poor oral hygiene. Review of the IPP dated April 25, 2007 failed to identified a toothbrushing program.	W 242	◆ QMRP will develop a toothbrushing program for client #3.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided an opportunity for clients choice for two of the four clients in the facility. (Clients #3 and #5) The findings includes: 1. The facility failed to ensure that Client #3 was provided an opportunity to participate in selecting his clothing. On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Client #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected by the staff for the client to wear on the next day. Review of client's IPP dated April 25, 2007 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the client] will make a selection of what clothes to wear daily in 80% of the trials presented for six	W 247	W247 This Standard will be met as evidenced by: ◆ QMRP will continue to implement strategies and training for direct care staff which focus on importance of choice / decision making and self management. 11.14.07 ongoing ◆ QMRP/Home Manager will monitor and provide oversight to further ensure that staff maintain attitudes and activities which promote individual choice.	

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 31 from 8:00 AM to 1:30 PM were observed and revealed the following: a) Upon the surveyors arrived to the home at 8:00 AM Client #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. b) At appoximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitative activities. c) At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. d) During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. e) After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride.	W 249	W249, Continued... ▪ QMRP/Home Manager will provide oversight and direction as needed to promote a consistent pattern of interactions and supports for each client. ▪ QMRP will review all program objectives to ensure that interventions and documentation of program objectives is sufficient number and frequency to support achievement.	11.20.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 32 2. Interview with staff on October 2, 2007 revealed that Client #4 dependents on staff for basic personal needs On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care skills had been identified/assessed. 3. Review of Client #4's IPP revealed that recommended training programs were not consistently implemented as evidenced below: Review of the Client #4's IPP revealed objectives to enhance sensory awareness, to improve lower range of motion and strengthen lower extremities, and to improve ambulation and auditory skills. At no time during the observations did the staff direct encourage, the client to participate in any of the aforementioned program objectives as evidenced below: a) Three times per week, the client will feel/manipulate items in his feel box for three minutes with hand over hand assistance for six consecutive months by 10/07. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007	W 249		

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 33 revealed that there was no box available with such items. Review of the data, however, revealed that the program was being implemented and that the client had acheived the required objective, since April. The facility QMRP could not explain how the program was being implemented without the box. b) [The client] will dance with staff for three minutes two times per day 100% accuracy for six months. Although the data collection refect that this program had been implemented in the past, there was no evidence that the program had been implemented during the survey period. Additionally, the data collected did not measure the progress of the objective. [Also See W252] d) [The client] will ambulate one trip around the interior of the home two times a day with moderate physical assistance of one person at 100% accuracy for six months". Although the October 2007 data collection refected that this program was being implemented one time a day, this program was not observed during the survey period. 2. The facility failed to implement Client #3's program objectives. a) Interview with the QMRP on October 2, 2007 at 9:40 AM indicated the Client #3 was admitted to the facility on March 26, 2007. During evening observation on October 2, 2007 from 3:45 through 6:55 PM, Client #3 was not	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 34 engaged in any formal or informal active treatment programs. At 3:30 PM, the client arrived home from his day program and shortly thereafter, at approximately 3:45 PM, was taken to his bedroom. He was observed to lie in bed until 6:55 PM. The client was observed to need total assistance in transferring from his wheelchair to and from bed. At 6:55 PM, the client was propelled into the living room and positioned in front of the television, where he remained until he received his G-tub feeding at 8:00 PM. There was no observation that the staff presented the client with a choice of leisure time activities or engaged the client in any other activty. b) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will sit on the edge of the bed for two minutes three times a day without assistance for three months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were documenting only twice a day. c) Review of Client #3's IPP dated April 25, 2007 revealed an objective that the client will tolerate stretching to his lower extremities daily for two minutes each stretch for six months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were not documenting the number of minutes. d) Review of client's IPP dated April 25, 2007	W 249	W249	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID1	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 35 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the client] will make a selection of what clothes to wear daily in 80% of the trials presented for six consecutive months by April 2008." On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Client #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected by the staff for the client to wear on the next day. There was no evidence that the facility encourage the client to participate in this task. 3. During the evening meal observation on October 2, 2007, Client #1 ate her meal with minimal to no assistance from staff. Upon the completion of the meal, the staff who was assisting the client with her meal, passed the dish and eating utensils to another staff person who was located in the kitchen. Review of the clients IPP objective on October 4, 2007, revealed that the client had a goal to increase her activities of daily living skills. To accomplish this goal, the client was required ". . . after dinner meal, given physical assistance, [Client Name] will remove her plate to the kitchen on 100% of the trials presented for six consecutive months." On October 2, 2007, Client #1 was not afforded an opportunity to participate in this IPP goal.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250	W250	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 250	Continued From page 36 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program for one of the four clients in the sample. (Client #4) The finding includes: Upon the surveyors arrived to the home at 8:00 AM, Client #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. At approximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitation activities. At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. At 12:30 During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the	W 250	W250, continued... This Standard will be met as evidenced by: ■ QMRP will provide additional training as needed for all staff on individualized schedules, location of active treatment schedules as well as implementation of schedules. ■ QMRP will modify change schedules as needed to allow flexibility, personal preferences and normal routine. ■ QMRP will develop schedules as needed for client #4.	11.20.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 250	Continued From page 37 client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride. Interview with the direct care staff and review of the habilitation record revealed that the client had no activity schedule for that day, and no record of an alterative activity schedule.	W 250		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to collected data that was reflective of actual client's performance for two of the five clients included in the facility. (Clients #2, and #4) The findings include: 1. Observation at the group home on October 2, 2007, at approximately 7:20 PM, revealed staff getting Client #2 out of her wheelchair and repositioning the client on a couch located in the foyer of the building. On October 3, 2007, Client #2's repositioning log was review and it was determined that the staff failed to document that the client had been repositioned on the previous day. The oversight	W 252	W252 This Standard will be met as evidenced by: #1 QMRP will provide additional staff training as needed to ensure that data is accurate and reflects the actual individual performance.	11-20-07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 38 was brought to the attention of the Qualified Mental Retardation Professional (QMRP) who acknowledged the documentation error. 2. During lunch, at approximately 12:30 PM, Client #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. On October 3, 2007, Client #4's data collection was review and it was determined that the staff failed to document that the client had exhibited face slapping on the previous day (10/2/07). 3. [Also see W196]	W 252	W252, continued... Also, reference response to W250 (3.) Reference response to W196	
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on review of clients individual program plans (IPPs), the interdisciplinary team (IDT) failed to make revisions or to justify the repetition of the objectives from the previous year, for two of the four clients included in the sample. (Clients #1 and #4)	W 260	W260 This Standard will be met as evidenced by: ■ QMRP received disciplinary actin for failing to effectively respond to and implement program monitoring and change.	10.31.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 39 The findings include: 1. Client #1's assessments, IPPs and documentation were reviewed on October 3, 2007. The IPPs identified in the client individual support plan (ISP) dated September 28, 2006 were continued from the previous ISP. Interview with the QMRP and the Residential Director acknowledged the following: a) The client's ISP had expired; b) The records failed to have current assessments c) The client program was continued from the previous year without justification. 2. During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 PM revealed that Client #4 was admitted into the facility on March 1, 2007. Client #4's assessments, IPPs and documentation were reviewed on October 3, 2007. The IPPs identified in the client individual support plan (ISP) dated September 28, 2006 were continued from the previous ISP. The written IPPs reflected that these program criterions and objectives were not revised. There was no documentation of interdisciplinary team review to justify continuation of the objectives during the March 2007 30 day admission meeting. 3. The facility failed to review and revise Client #1's programs annually as evidenced by the following:	W 260	W260 ◆ Current ISP has been filed. ◆ QMRP will document individual progress, modifications and interdisciplinary team reviews. ◆ QMRP will review all program objectives modify/change as needed. ◆ QMRP will follow-up and address expired IPP's assessments.	11-20-07 ongoing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 40 Review of Client #1's program records on October 3, 2007 revealed that her last Individual Support Plan (ISP) meeting was held on August 1, 2006. Interview with the QMRP on the same day revealed that the client's ISP meeting was to held on October 5, 2007 due to a decision made the Judge. Review of Client #1's program objectives and assessments revealed that they were all outdated and that the IPP programs and objectives had not been revised.	W 260		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure program which incorporate restrictive techniques and use of behavior modification were conducted only with written informed consent of the client, or legal guardian for one of the four clients in the the sample. (Client #4) The finding includes: There was no evidence of written informed consent for the use of Client #4's Behavior Support Plan prior to the implementation of which included restrictive measures. [See W124]	W 263	W263 This Standard will be met as endemed by; ■ QMRP will obtain written informed consent for use of client #4's behavior support plan. ■ Also, reference response to W124 ■ In future, QMRP will make sure that written consent is present prior to implementation.	11.20.07 ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 41 This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure general and preventive care for two of the four clients in the sample. (Clients #3) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM indicated that Client #3 was admitted to the facility on March 26, 2007. Review of the client's 30 day meeting review revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended: - knee brace to increase his extension range of motion; and - an evaluation at the spasticity clinic for Botox injections to facilitate improving his knee extension. Interview with the QMRP on October 3, 2007 at approximately 12:30 PM, revealed that the an appointment had not been scheduled for the knee brace or an evaluation at the spasticity clinic. 2. The facility failed to ensure weight loss was reported to the Physician timely and monitored by a dietician as evidenced below: "Since March 2007, Client #1 has lost 13 pounds, which is over 10% of her body weight. There was no evidence that Client #1 ' intake is being closely monitored and recorded or that there was follow-up to her incomplete study/pelvic	W 322	W322 This Standard will be met as evidenced by: ■ An appointment has been scheduled for client #3. ■ Evaluation was done on 10/31/07 for knee brace. ■ Client # 3 will be evaluated to determine if he is a candidate for botox injection.	11.20.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 42 sonogram, which took place on June 29. 2007. " Client #1 was a 60 year old female with diagnosis of cerebral palsy, seizure disorder, hypercholesteremia, profound mental retardation, Reynaud ' s disease, malignant melanoma with last toe of right leg amputated. Her diet order was low fat/cholesterol, chopped with added fiber, ground hot dogs and turkey bacon. According to a nutritional assessment dated August 31, 2006, Client #1 had an ideal body weight (IBW) of 85 - 110 pounds. Review of the client ' s weight charts revealed the following: (All weights were recorded in pounds) January 2006 - 106, Febrary 2006 - 106 March 2006 - 106 April 2006 - 106 May 200 - 106 June2006 - 107 July 2006 - 110 August 2006- 105 September 2006 - 105 October 2006 - 107 November 2006 - 105 December 2006 - 106 January 2007 - 106, Febrary 2007 - 106 March 2007 - 106 April 2007 - 97 May 2007 - 93 June2007 - 94 July 2007 - 93.3 August 2007- 93 September 2007 - 92.7 October 2007 - 92	W 322	W322 ■ RN will conduct additional training for LPN staff on monitoring weight gain/loss trends. ■ Nurses will be expected to immediately report concerns to RN and primary care physician. ■ Observations show client #1 has a good appetite and food continues to be monitored at each meal.	11.20.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 43 Review of the above weight chart reveals that Client #1 had a significant decrease in weight of 9 lbs in one month from March 2007, to April 2007. Since that time there has been a continued gradual decrease in Client #1 ' weight. A total of 13 lbs was documented from March 2007 to October 2007. Interview with the RN on October 18, 2007 revealed that the facility nurse is required to obtain monthly weight and report 5 lb increases or decreases in weight to the Primary Care Physician and/or the Dietician. Ms Relera verified that the record lacked evidence that the nurse reported the April 7, 2007 9 lb weight loss to the medical or dietary staff. According to the record and the RN, the PCP was not made aware of Client #1 ' weight loss until May 2, 2007; (nearly one month later). Prior to the weight loss, Client #1 complained of abdominal pain. On March 21, 2007, she was evaluated by a gastroenterologist to rule out a possible upper quadrant mass. A mass was not palpable on examination; however the GI specialist recommended an ultrasound of the abdomen. The sonogram was completed on April 2, 2007. The test was described as suboptimal, however was noted to be " grossly unremarkable. " She continued to be followed by the GI specialist, and on June 11, 2007 the specialist recommended that a CT scan of the abdomen be completed. The study was completed on Jun 11, 2007. There was no evidence of obstruction noted; however the radiologist recommended that a pelvic sonogram be performed for further evaluation. The Pelvic sonogram was completed on June 29, 2007, and revealed " no significant findings. " Upon his notification of the weight loss on May 2, 2007, the	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 44 PCP ordered a chest x-ray (posterior and lateral views). The study was completed on May 7, 2007 and was found to be normal. Interview with the facility's Residential Director, on October 4, 2007 revealed that the facility had a very reliable dietician [Dietician #1], who discontinued her services with the provider. The provider contracted with [Dietician #2] to provide nutritional oversight for the clients. Ms. Branch indicated that " we are finding out that Dietician #2was not providing the nutritional oversight as we thought she was. " The Residential Director stated that they are no longer using Dietician #2's services and that Dietician #1 was the facility ' s dietician. On October 19, 2007, the investigator requested the contracts for both Dietician #1 and Dietician #2. The residential Director was sure that there was a contract for Dietician #1 but was not sure if there was a contract with Dietician #2. Dietician #1 was in the facility on October 2, 2007. In an interview on October 3, 2007, Dietician #1 indicated that she had taken a year off and was not aware that the facility was without a reliable dietician in her absence. Dietician #1 reviewed the client ' s record and documented quarterly reviews for the months missing in the record. Interview with the day program staff on October 2, 2007, revealed that the client Is a picky eater and that some days she eats better than others. The staff did not know if whether the days the client did not eat well were due to the client not liking the food being served. The nurse at the day program on the same day revealed that she did look at the clients weights monthly, however did not see a need in monitoring the client ' s intake since she was within her ideal body weight range.	W 322	W322. Nutritionist will continue to monitor weight loss/ gain and write quarterly and/or as needed documentation to reflect interventions taken.	11.14.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 45 Review of the physician ' s orders reflected that the client ' s weight should be weighed monthly. Observations at the day program and the facility throughout the investigation revealed that Client #1 ate 100% of the meals observed. Although the nurses documented the client ' s weights monthly as ordered, the nurse discovering the weight loss on April 7, 2007 did not informed the nutritionist or the physician. The physician was not informed of the client ' s weight concerns until May 2, 2007. There was no evidenced that the facility employed a dietitian to provide consistent nutritional oversight to Client #1 from August 2006 to October 1, 2007. 3. The facility failed to implement recommendations made by Client #2's Neurologist regarding obtaining monthly Dilantin and Phenobarbital levels as evidenced by the following:. Review of Client #2's neurology consultations revealed that she was seen on August 2, 2007. The Neurologist recommended obtaining monthly Dilantin and Phenobarbital levels, along with other laboratory studies. The client was to return to his office with all lab results in two months. The Primary Care Physician (PCP) concurred with the Neurologists ' recommendation and ordered the test on August 2, 2007. The test were completed and resulted in the following: September 18, 2007 - Dilantin 7.3? Normal Value - 10 - 20 Phenobarbital 17 15 - 40	W 322	▲ Recommendations for lab work will be completed in a timely manner as ordered. ▲ Client #2's follow-up visit with the neurologist completed this month. Nueroglogist ordered Dilantin & Phenobarbital levels be taken q 2 months. ▲ RN will continue to conduct routine record reviews to ensure that labs are done as ordered.	11.14.07 ongoing

DEPARTMENT OF HEALTH

HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL STREET NE, 2ND FLOOR
WASHINGTON, DC 20002
FAX NOS. 202-442-9430 OR 202-442-9431

FACSIMILE TRANSMITTAL SHEET

TO: Mr. Ron Raghunandan	FROM: Ms. L. Wallace-202-442-4721 Admin. Support Specialist
COMPANY: Individual Development, Inc.	DATE: 10/22/2007
FAX NUMBER: 202-518-9685	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 202-518-0314	SENDER'S REFERENCE NUMBER:
RE: **ENFORCEMENT**	YOUR REFERENCE NUMBER:

☐ URGENT ☑ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

FOR THE FOLLOWING FACILITIES:

1. **4515 Edson Pl NE**

Please be advised that typed document will follow.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 46 October 1, 2007 - Dilantin 16.2 Phenobarbital 20 Review of the laboratory reports revealed that the test (Phenobarbital and Dilantin) were completed over 30 day after the order. Interview with the facility ' s nurse on October 4, 2007 confirmed the untimely laboratory studies. 4. The facility failed to address Client #5's 8.5 pounds weight loss as evidenced below: According to a nutritional assessment dated August 31, 2006, Client #5 had an ideal body weight (IBW) of 93 - 122 pounds. Review of the client ' s weight charts revealed the following: (All weights were recorded in pounds) January 2006 - 104, Febrary 2006 - 104 March 2006 - 106 April 2006 - 108.5 May 200 - 110.5 June2006 - 111.05 July 2006 - 113 August 2006- 115 September 2006 - 116 October 2006 - 113 November 2006 - 112 December 2006 - 113 January 2007 - 121, Febrary 2007 - 120 March 2007 - 120 April 2007 - 115 May 2007 - 112 June2007 - 113 July 2007 - 113 August 2007- 111.5	W 322	W322 ■ Client #5's weight remains stable ■ Thyroid function list negative. 10.18.07. ■ 10.29.07 CT scan of abdomen and pelvis completed. ■ Nutritionist will continue monitor weight and make as needed. ■ Nursing staff will consult with primary care physician as needed.	10.18.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 47 September 2007 - 111.9 October 2007 - 112 Review of the above weight chart reveals that although Client #5 had an 8.5 lbs decrease in weight from March 2007, to August 2007; she remains well within her ideal body weight. The record failed to show evidence that the client's nutritional status had been consistently monitored by a dietician quarterly as required. As indicated above, the facility ' s Residential Director acknowledged that the there was a laps in nutritional monitoring at the facility. A new dietician has been hired at this time. The new Dietician has reviewed all of the clients ' records and has made an assessment of each client ' s current nutritional status. The lack of nutritional oversight was acknowledged by the Residential Director, however at the time of the survey/ investigation, the provider had hired a new dietician who was at the facility on October 2, 2007conducting assessments and chart reviews of the clients in the facility.	W 322		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the	W 325	W325 This Standard will be met as evidenced by:	10.18.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 325	Continued From page 48 physician for one of the five clients included in the sample. (Client #2) The finding includes: Review of Client #2's Neurology consultations on October 3, 2007 at approximately 12:50 PM revealed that she was seen on August 2, 2007. The Neurologist recommended obtaining monthly Dilantin and Phenobarbital levels, Complete Metabolic panels, and Complete blood count with differentials twice per year. The client was to return to his office with all lab results in two months. A physician order reflecting the recommendations was noted in the record. Review of the laboratory reports revealed that the aforementioned labs ber completed July 9, 2007, however the record lacked evidence that a Phenobarbital and Dilantin level was obtained in August 2007. Interview with the facility ' s nurse on October 4, 2007 revealed that blood levels should have been drawn in August as ordered. It should be noted that the Phenobarbital and Dilantin levels were obtained in September 18, 2007, and reflected that the Dilantin level was 7.37 (Normal Value 10 - 20) and the Phenobarbital level was 17 (normal value 15-40) The levels were drawn again in October 1, 2007. The Dilantin level was 16.2 and the Phenobarbital level was 20. It was noted that the PCP evaluated Client #2 on September 22, 2007. There were no new orders given at that time regarding the low Dilantin level.	W 325	W325 • Reference response to W322. • Routine screening will be conducted as ordered. • Documentation will be maintained on file.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 49 This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of three of four clients in the sample. (Clients #2, #3 and #4) The findings include: 1. The facility's LPN failed to follow Client #3's physician order that required the nurse to give pleasure feeding 15 minutes after regular scheduled feeding. On October 3, 2007 at 10:35 AM, the Licensed Practical Nurse (LPN) was observed feeding Client #3 through his G-tube. The G-tube feeding ended at 11:05 AM. At 11:08 AM, the LPN was observed feeding the client his pleasure feeding of cranberry juice. Interview with the LPN indicated that the client had been doing well with his pleasure feeding. Review of Client #3's current physician order required the client to receive pleasure feedings 15 minutes after each schedule G-Tub feeding (11:00 AM, 4:00 PM and 8:00 PM). Further interview with the Registered Nurse on October 3, 2007 at approximately 2:00 PM revealed that the client should wait the required 15 minutes to ensure that his stomach was "not overloaded with liquids." 2. The facility's nurse failed to schedule medical consultation appointments for Client #3, timely. a. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Client #3 was admitted to the	W 331	W331 ■ RN will provide additional training as needed on pleasure feeding as ordered. ■ RN will conduct random observations to ensure compliance with this standard. ■ Reference response to W322, knee brace.	10.18.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 50 facility on March 26, 2007. October 2 - 5, 2007 the client was observed in a wheelchair. Review of client's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the client be fitted for a knee brace. b. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Client #3 was admitted to the facility on March 26, 2007. Observations during the survey from October 2 - 5, 2007, the client was observed in a wheelchair with tight limbs. Review of client's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the client receive an evaluation at a spasticity clinic. 3. The facility's nurse failed to obtain PSA lab results for Client #4. Review of Client #4's medical record revealed a physician order for the client to receive a PSA level. According to the lab profiles the test was administered on July 12, 2007. At the time of survey, however, there were no PSA results, available. 4. The facility's nurse failed to obtain Dilantin and Phenobarbital levels as ordered by the physician as evidenced by the following: Client #2 was observed receiving Dilantin 150 mg and Phenobarbital 90 mg on October 2, 2007, at 6:35 PM. Review of the client' s neurology consultations revealed that she was seen on August 2, 2007. The Neurologist recommended obtaining monthly Dilantin and Phenobarbital	W 331	W331 PSA level was completed on 7-12-07 and faxed on 7-13-07 - document is on file.	10-6-07 ongoing

PRINTED 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 51 levels, complete metabolic panels, and complete blood count with differentials twice per year. The client was to return to his office with all lab results in two months. A physician order reflecting the recommendations was noted in the record. Review of the laboratory reports failed to evidence that a Phenobarbital and Dilantin level was obtained in August 2007, however one was obtained September 2007. Interview with the facility ' s nurse on October 4, 2007 revealed that blood levels should have been drawn in August as ordered. 5. The facility failed to obtain a swallowing study for Client #4. Observations during the meals throughout the survey from October 2 - 5, 2007 revealed that Client #4 was served a pureed diet. Review of the Client #4's medical record revealed a physician order dated June 19, 2007, for a swallow study. Further review of the records revealed that the study had been scheduled for December 18, 2007, 6 months after the order. 6. Observations on October 2, 2007 at approximately 7:30 PM, Client #4 was observed wearing adult protective undergarments. Interview with the direct care staff indicated that the client wears diapers. Review of the client's nursing notes on October 4, 2007 at approximately 11:00 AM revealed that the client had a urology consult on July 26, 2007 and should return in one year. However, there was no medical consultation sheet to confirm that the appointment had been completed. 7. The facility's nurse failed to ensure that Client	W 331	(5.) Reference response to W322 - Urology appointment was completed on 9/26/07 Nursing entry was an error. Wrote 7.26.07 instead of 9.26.07. (6) Reference response to W322, W325, W336	11.14.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 52 #2's health status was reviewed by the Registered Nurse on a quarterly or more frequent basis. [See W336]	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis for one of the four clients in the sample. (Clients #2) The finding includes: Review of Client #2's medical record revealed that her annual nursing assessment was completed on June 16, 2007. Further review of the medical record revealed that the first quarter assessment had not been completed. Interview with the Registered Nurse confirmed that the quaterly assessment had not been completed.	W 336	W336 This Standard will be met as evidenced by: ■ First quarterly assessment has been completed. ■ RN will conduct a quarterly assessment and more frequently depending on the needs of the client.	10.18.07; ongoing
W 343	483.460(d)(1) NURSING STAFF Nurses providing services in the facility must have a current license to practice in the State. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that all nurses providing services in the facility had a current license to practice in the District of Columbia.	W 343	W343 This Standard will be met as evidenced by:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 343	Continued From page 53 The finding includes: Review of personnel records on October 4, 2007 at 8:15 AM failed to provide evidence of the credentials for the two nurses. The facility failed to provide evidence of a current license for all of the nurses to practice in the District of Columbia in accordance with the Health Occupation Revision Act (HORA) Title 3 Chapter 12 Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	W 343	W343, continued... ■ Human Resource Department will obtain current licenses for all ... staff. ■ Human Resource Department will continue to track and monitor expiration dates & send notices to identified staff prior to expiration.	10.6.07 ongoing
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain water temperatures not to exceed 110 degrees Fahrenheit. The finding includes: On October 4, 2007 at 1:00 AM, the hot water temperature felt hot to the touch. Readings from the surveyor's thermometer was 120 degrees Fahrenheit in the kitchen and both bathrooms. The Facilities Coordinator was informed at approximately 1:10 AM, who informed the maintenance staff and instructed him to lower the water temperature. On October 5, 2007 at 1:00 PM, the hot water	W 426	W426 This Standard will be met as evidenced by: ■ Staff are required to check the hot water temperature daily on each shift, upon arrival and before bathing. ■ Staff will continue to document readings and report all concerns immediately. ■ Home Manager will continue to monitor and provide additional training as needed.	10/6/07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 426	Continued From page 54 temperature had been adjusted not to exceed 110 degrees Fahrenheit.	W 426		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and provided for one of the four clients included in the sample. (Client #3) The finding includes: The facility failed to furnish the recommended adaptive equipment for Client #3. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM indicated that Client #3 was admitted to the facility on March 26, 2007. Review of the client's 30 day meeting review revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended: - knee brace to increase his extension range of motion; and - an evaluation at the spasticity clinic for Botox injections to facilitate improving his knee	W 436	W436 This Standard will be met as evidenced by: ■ QMRP will follow-up to ensure that recommended ■ The appointment has been scheduled for client # 3 for evaluation of knee and brace. ■ QMRP in coordination with the medical staff will address the recommendation for Botox injections to include the benifits and potential risks related to treatment. ■ Documentation related to actions taken to address	11.21.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 55 extension. Interview with the QMRP on October 3, 2007 at approximately 12:30 PM, revealed that the an appointment had not been scheduled for the knee brace or an evaluation at the spasticity clinic.	W 436	W436. continued will be filed for review.	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: On October 3, 2007, at 7:55 AM a review of fire drill records revealed that fire drills had not been held during the hours of 2 AM through 5 AM. Observations throughout the survey revealed that there are eight non-mobile clients that reside in the facility who are completely dependent upon the staff. In an interview with the House Manager on the same day, she revealed that there are two direct care staff and one nurse on duty during the night. Further interview the House Manager acknowledged that there had not been a drill during the aforementioned hours to evaluate how the three staff at night would safely evacuate the eight non-mobile clients in the facility.	W 441	W441 This Standard will be met as evidenced by: - Home Managers must ensure that there are at least one drill on each shift every month. - Home Managers must check documentation and provide additional follow-up as needed. - Home Manager will ensure that drills are conducted under varied conditions, at different times, and places and escape routes.	11.13.07 ongoing
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	W455	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 56 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infectious control procedures to prevent communicable infectious diseases. The findings include: 1. The facility failed to properly defrost meats in preparation for dinner. On October 2, 2007 from 1:00 PM until 4:00 PM, a package of raw pork chops was observed sitting on the counter top. The package of pork chops was warm to touch. Review of the dinner menu indicated that pork chops was on the menu for dinner. 2. The facility failed to ensure that direct care staff washed her hands prior to feeding Client #4 his lunch. On October 2, 2007 at 12:30 PM, Staff #1 was observed having difficulty in getting Client #4 to complete his lunch. At 12:50 PM, Staff #2 come into the facility from off the van and stated, "I will get [the client] to eat his lunch." Staff #2 was observed feeding the client his lunch to completion. Staff #2 was not observed to wash her hands prior to feeding the client. The facility staff failed to ensure that the policy and procedures were implemented as it relates to infection control measures during meals.	W 455	W455 This standard will be met as evidenced by: • QMRP/Home Manager will coordinate additional staff training in area of Nutritional Management — 11.18.07 ongoing • QMRP/Home Manager/nurse will continue to monitor meal preparation, provide direction and feedback as needed to ensure compliance with infection control procedures • QMRP will post additional hand washing signs.	
W 461	483.480(a)(2) FOOD AND NUTRITION SERVICES A qualified dietitian must be employed either	W 461	W461	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 461	Continued From page 57 full-time, part-time, or on a consultant basis at the facility's discretion. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have evidence that it employed a qualified dietician to meet the client's needs for two of the five cleints in the sample. (Client's #1 and #5) The finding includes: 1. Client #1's record was reviewed on October 3, 2007. The client had a nutritional assessment on August 31, 2006. Review of the clients weight records revealed that she had lost 9 pounds (lbs) from March to April 2007, and continued to gradually lose weight. The last record weight was in October 2007 and the client weight 92 lbs. It was noted, however that she remained within her ideal body weight of 85 - 110 lbs. Further review of the record failed to show evidence that the client's nutritional status had not been monitored by a dietician quarterly (1st quarter September 2006, October 2006, and November 2006, and 2nd quarter December 2006, January2007, and February 2007)as required. [See Also W322] 2. According to a nutritional assessment dated August 31, 2006, Client #5 had an Ideal body weight (IBW) of 93 - 122 pounds. Review of the client ' s weight charts revealed that although Client #5 had an 8.5 lbs decrease in weight from March 2007, to August 2007; she remains well within her ideal body weight. Further review of the record lacked evidence that the client's nutritional status had been monitored by a dietician quarterly (1st quarter September 2006,	W 461	W461 This Standard will be met as evidenced by: (1.) Reference response to W322 (2) Reference response to W322 W325, W331	10.18.07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 461	Continued From page 58 October 2006, and November 2006, and 3rd quarter March 2007, April 2007, and May 2007)as required. The nutritionist was in the facility on October 2, 2007. In an interview conducted on October 3, 2007, she indicated that she had taken a year off and was not aware that the facility was without a reliable dietician in her absence. She indicated that the provider had re-hired her and that she had completed nutritional assessment on all of the clients on October 2, 2007. Review of the records verified that the nutritionist completed all necessary assessments which were dated October 2, 2007. Interview with the facility's Administrator on October 4, 2007 revealed that the facility current dietician who was re-hire was "very reliable." However, due to her subbatical, the provider contracted with another dietician, who was not providing the nutritional oversight as required in his/her contracted.	W 461	Reference response to W322, W331, W325.	10.18.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS On October 2, 2007, a recertification survey in conjunction with a complaint investigation was conduct through October 5, 2007, utilizing the full survey process. A random sample of four was selected from a residential population of two male and six females clients with a diagnosis of profound mental retardation. The findings of the survey and investigation were based on observation at the group home and three day programs, interviews with group home staff, day placement staff, the nutritionist, the administrator, the Qualified Mental retardation Professional, review of medical and administrative records including the unusual incident reports. On September 28, 2007, the State Agency received an e-mail from the court monitor's office that described client's care and treatment concerns. The compliant alleged that there were persistent pattern of problems as detailed below: 1. "Upon the individuals' return home from their day program, water/fluids were not given or offered a second time to individuals who initially resisted/refused the water/fluids. In addition, individuals were not toileted or changed upon their return home." 2. "Throughout the observation period, one of the four staff members on duty spent the majority of the time preparing dinner while the other three staff members sporadically interacted with the individuals." 3. "Class members' logs of community outings revealed that they had participated in only two outings during the period of September 1 - 19,	I 000		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Continued From page 1 2007 - park and church. There was no evidence that any community outings occurred in August 2007." 4. "As noted in the prior reviews, direct care staff members, as well as the nurse on duty at the time of the review, lacked basic knowledge of the class members' current health care problems and needs." 5. "As noted in the prior reviews, class members' positioning logs indicated that they spend the majority of their day sitting in their wheelchairs." 6. "On August 24, 2007, when Resident #2 returned from her day program, she was "found" with a laceration on the right side of her forehead. Resident #2 was taken to the emergency room, treated, and released with staple(s) in her forehead, which were to be removed in seven days. This serious reportable incident was not reported to the court monitor's office." 7. "There was no evidence that Residen t#2's neurologist's 8/2/07 recommendation to obtain monthly Dilantin and Phenobarbital levels for Resident#2 was implemented." 8. "Since March 2007, Resident #1 has lost 13 pounds, which is over 10% of her body weight. There was no evidence that Ms. Resident#1's intake is being closely monitored and recorded or that there was follow-up to her incomplete study/pelvic sonogram, which took place on June 29, 2007." 9. "There was no evidence that Resident #1's dietician had conducted a review and assessment of the changes in Residen t#1's nutrition status and her weight loss. The most	I 000		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Continued From page 2 recent nutrition assessment filed in Resident#1's record was dated 8/13/06, and it was no longer a current or accurate portrayal of the client's nutrition/weight status." 10. "In addition, although Resident #1's physician, registered nurse, and agency Director of Nursing were notified of Resident #1's abnormal blood-glucose levels of 39 (obtained on 8/21/07) and 54 (obtained on 8/27/07), each of which represented a marked changed from her blood-glucose level of 98 in April 2007, there was no evidence any follow-up to these abnormalities." 11. "Since March 2007, Resident #5 has also sustained an unexplained weight loss of 8.5 pounds. As noted in the prior review, neither Resident#5's nurses' nor her QMRP's reports addressed the client's weight loss." 12. "The numerous copies of the class members' Health Risk Management Plans, which were filed across the class members' Medical, ISP, and Program records, were not complete, current, or accurate."	I 000		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that meals served away from the GHMRP suited the	I 047	1047 3502 This Statute will be met as evidenced by; Reference response to W120. Federal Deficiency Report.	

PRINTED 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 047	Continued From page 3 residents dietary needs for one of the four residents in the facility. (Resident #1) The finding includes: On October 2, 2007 at 7:20 AM, Resident #1 was observed using an angled spoon during her breakfast. On October 2, 2007 at the day program, the client was observed eating her lunch. The client had an adaptive plate and built up handled spoon. At the dinner meal on the same day the resident utilized an angled spoon for eating. Record reveiw revealed that the resident was prescribed an angled spoon during meals. The day program observation was brought to the attention of the Qualified Mental Retardation Professional (QMRP), who was not aware that the day program was not using the recommended adaptive feeding equipment at her day program.	I 047		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP ty failed to ensure that each GHMRP staff was trained in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. The finding includes: The facility failed to properly defrost meats in	I 056	I056 3502.14 This Statute will be met as evidenced by;	

PRINTED 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 056	Continued From page 4 preparation for dinner. On October 2, 2007 from 1:00 PM until 4:00 PM, a package of raw pork chops was observed sitting on the counter top. The package of pork chops was warm to touch. Review of the dinner menu indicated that pork chops was on the menu for dinner.	I 056	CMRP will review and discuss proper preparation and sanitation expectations. CMRP/Home manager will schedule additional training as needed in Nutritional Management.	
I 061	3502.19 MEAL SERVICE / DINING AREAS Each GHMRP shall have effective procedures for cleaning all equipment and work areas used in the preparation and serving of foods. This Statute is not met as evidenced by: The finding includes: On October 2, 2007, the food processor was sitting on the kitchen counter top with water drops on it.	I 061	1061 3502.19 This Statute will be met as evidenced by: ☑ Food processor had just been rinsed off and about to be placed in dish washer for cleaning when observation completed. ☑ Home Manager will review cleaning equipment procedures and monitor work areas to further ensure compliance with this standard.	10.6.07 ongoing
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to have apporapriately fitting clothes for one of the four residents in the sample. (Resident #1) The finding includes: On October 2, 2007 Resident #1 shirt appeared	I 108	3504.15 Reference response to W137 federal deficiency report.	10.31.07 ongoing

PRINTED 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 056	Continued From page 4 preparation for dinner. On October 2, 2007 from 1:00 PM until 4:00 PM, a package of raw pork chops was observed sitting on the counter top. The package of pork chops was warm to touch. Review of the dinner menu indicated that pork chops was on the menu for dinner.	I 056	QMRP will review and discuss proper preparation and sanitation expectations. QMRP/Home Manager will schedule additional training as needed in Nutritional Management.	
I 061	3502.19 MEAL SERVICE / DINING AREAS Each GHMRP shall have effective procedures for cleaning all equipment and work areas used in the preparation and serving of foods. This Statute is not met as evidenced by: The finding includes: On October 2, 2007, the food processor was sitting on the kitchen counter top with water drops on it.	I 061	1061 3502.19 This Statute will be met as evidenced by: ■ Food processor had just been rinsed off and about to be placed in dishwasher for cleaning when observation completed. ■ Home Manager will review cleaning equipment procedures and monitor work areas to further ensure compliance with this standard.	10.6.07 ongoing
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to have apporapriately fitting clothes for one of the four residents in the sample. (Resident #1) The finding includes: On October 2, 2007 Resident #1 shirt appeared	I 108	3504.15 Reference response to W137 Federal deficiency report.	10.31.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 108	Continued From page 5 too big as the arms of the shirt hung over her hands. Interview with the staff acknowledged that the resident's clothes were two large and indicated that she had recent weight loss. Interview with the Qualified Mental Retardation Professional (QMRP) also acknowledged that the resident has loss weight and that the day program had been concerned with her clothes being too big.	I 108		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: On October 3, 2007, at 7:55 AM a review of fire drill records revealed that fire drills had not been held during the hours of 2:00 AM through 5:00 AM. Observations throughout the survey revealed that there are eight non-mobile residents that reside in the facility who are completely dependent upon the staff. In an interview with the House Manager on the same day, she revealed that there are two direct care staff and one nurse on duty during the night. Further interview the House Manager acknowledged that there had not been a drill during the aforementioned hours to evaluate how the three staff at night would safely evacuate the eight non-mobile residents in the facility.	I 135	I135 3505.5 This Statute will be met as evidenced by; • Home Manager will conduct routine fire drills at various times. • Home Manager will conduct additional staff training as needed.	11.6.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 6	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on October 4, 2007, at which time there was no evidence that two direct support staff, [Staff # 10 and #11] , one agency support staff, [Staff #12] two nurses and two professional health care consultants had current health certificates.	I 206	1206 3509.6 This Statute will be met as evidenced by: ● Health Certificates for two direct support staff [#10 and #1], one agency support staff #12 two nurse and two professional health care consultants have been filed. ● Human Resource Dept will continue to track/monitor and request verification of health reviews.	11.14.07 ongoing
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on record review the GHMRP failed to ensure each residents records were dated and signed by the individual completing the assessment or monitoring the lab profiles.	I 291	1291 3514.2 This Statute will be met as evidenced by:	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 7 The findings include: 1. The facility's primary care physician failed to date his entry for Resident #1's abnormal laboratory profiles. Review of the complaint received on September 28, 2007, revealed that Resident #1 had blood drawn on August 18 and 24, 2007. The blood glucose results were 39 and 54 respectively. These results were noted as being below the normal range documented as 74 - 105. Review of the laboratory report dated August 18, 2007 revealed that the Primary Care Physician reviewed the results', however he did not date his entry it could not be determined if the results were reviewed timely. 2. The facility's Registered Nurse (RN) failed to sign Resident #4's quarterly reviews. Interview with the facility's Licensed Practical Nurse (LPN) on October 4, 2007 at approximately 3:00 PM revealed that the one of two RN completes quarterly nursing exams. Review of the Resident #4's medical record revealed that a nursing assessment was completed in March 2007, with quarterly follow ups (June 2007, September 2007). However, the quarterly reviews were not signed to indicated who had completed the quarterly reviews.	I 291	(1.) Reference response to federal deficiency report W322.	10.18.07
			(2.) Reference response to federal deficiency report W322	10.18.07 ongoing
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as	I 374	1374 3519.5	

PRINTED 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 8 soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for one of the four residents in the sample. The finding includes: Review of the facility's unusual incident reports and investigations on October 2, 2007 at approximately 8:20 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents: a. On April 17, 2007, staff discovered Resident #2 with a three centimeter discoloration on her left thigh. b. On August 24, 200, Staff discovered a laceration to Resident #2's head for which she was treated in the emergency room.	I 374	This Statute will be met as evidenced by: Reference response to W153 and W154. of Federal Deficiency report.	11.18.07 ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379	1379 3519.10 This Statute will be met as evidenced by: Reference response to W153 and W154 of Federal Deficiency Report.	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 9 This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of unusual incidents or events that substantially interfered with each resident's health and welfare within twenty-four hours or the next work day. The finding includes: Review of the incident reports on October 2, 2007 beginning at 8:20 AM revealed the following incidents had not been reported to the State Agency as required: a. On April 17, 2007, staff discovered Resident #2 with a three centimeter discoloration on her left thigh. b. On September 11, 2007, the staff discovered a "mark" on Resident #3's left back arm. c. On July 16, 2007, the staff discovered a scratch on Resident #3's right back leg. d. On July 9, 2007, the staff discovered an abrasion on Resident #3's left lower leg. e. On June 24, 2007, the staff discovered a bruise on Resident #6's right elbow. f. On June 18, 2007, the staff discovered a blister on Resident #7's right knee.	I 379	a QMRP received corrective Action for failure to to notify Department of Health of incidents. a QMRP will ensure that all incidents are reported and investigated in a timely manner. a Documentation/verification will be maintained on file to support actions taken.	11.20.07 ongoing
I 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified	I 394	1394 3520.2.(d)	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 394	Continued From page 10 professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (d) Nutrition; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have evidence that it employed a qualified dietician to meet the Resident's needs for two of the five cleints in the sample. (Resident's #1 and #5) The finding includes: 1. Resident #1's record was reviewed on October 3, 2007. The Resident had a nutritional assessment on August 31, 2006. Review of the Residents weight records revealed that she had lost 9 pounds (lbs) from March to April 2007, and continued to gradually lose weight. The last record weight was in October 2007 and the Resident weight 92 lbs. It was noted, however that she remained within her ideal body weight of 85 - 110 lbs. Further review of the record failed to show evidence that the Resident's nutritional status had not been monitored by a dietician quarterly (1st quarter September 2006, October 2006, and November 2006, and 2nd quarter December 2006, January2007, and February 2007)as required. [See Also W322] 2. According to a nutritional assessment dated	I 394	This Statute will be met as evidenced by: - Nutritionist will provide quarterly and/or as needed oversight. - RN/Nurse/QMRP will coordinate services as needed. - Primary Care Physician will be notified of unusual weight trends increase/decrease 5lbs. - Also reference response W322 Federal deficiency report.	10.18.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 394	Continued From page 11 August 31, 2006, Resident #5 had an ideal body weight (IBW) of 93 - 122 pounds. Review of the Resident ' s weight charts revealed that although Resident #5 had an 8.5 lbs decrease in weight from March 2007, to August 2007; she remains well within her ideal body weight. Further review of the record lacked evidence that the Resident's nutritional status had been monitored by a dietician quarterly (1st quarter September 2006, October 2006, and November 2006, and 3rd quarter March 2007, April 2007, and May 2007)as required. The nutritionist was in the GHMRP on October 2, 2007. In an interview conducted on October 3, 2007, she indicated that she had taken a year off and was not aware that the GHMRP was without a reliable dietician in her absence. She indicated that the provider had re-hired her and that she had completed nutritional assessment on all of the Residents on October 2, 2007. Review of the records verified that the nutritionist completed all necessary assessments which were dated October 2, 2007. Interview with the GHMRP's Administrator on October 4, 2007 revealed that the GHMRP current dietician who was re-hire was "very reliable." However, due to her subbatical, the provider contracted with another dietician, who was not providing the nutritional oversight as required in his/her contracted.	I 394		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every	I 395	1395 3520.2(e) This statute will be met as evidenced by:	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 12 individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the GHMRP failed to ensure nursing services in accordance with the needs of three of four Residents in the sample. (Residents #2, #3 and #4) The findings include: 1. The GHMRP's LPN failed to follow Resident #3's physician order that required the nurse to give pleasure feeding 15 minutes after regular scheduled feeding. On October 3, 2007 at 10:35 AM, the Licensed Practical Nurse (LPN) was observed feeding Resident #3 through his G-tube. The G-tube feeding ended at 11:05 AM. At 11:08 AM, the LPN was observed feeding the Resident his pleasure feeding of cranberry juice. Interview with the LPN indicated that the Resident had been doing well with his pleasure feeding. Review of Resident #3's current physician order required the Resident to receive pleasure feedings 15 minutes after each schedule G-Tub feeding (11:00 AM, 4:00 PM and 8:00 PM). Further interview with the Registered Nurse on October 3, 2007 at approximately 2:00 PM revealed that the Resident should wait the	I 395		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 13 required 15 minutes to ensure that his stomach was "not overloaded with liquids." 2. The GHMRP's nurse failed to schedule medical consultation appointments for Resident #3, timely. a. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Resident #3 was admitted to the GHMRP on March 26, 2007. October 2 - 5, 2007 the Resident was observed in a wheelchair. Review of Resident's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the Resident be fitted for a knee brace. b. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Resident #3 was admitted to the GHMRP on March 26, 2007. Observations during the survey from October 2 - 5, 2007, the Resident was observed in a wheelchair with tight limbs. Review of Resident's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the Resident receive an evaluation at a spasticity clinic. 3. The GHMRP's nurse failed to obtain PSA lab results for Resident #4. Review of Resident #4's medical record revealed a physician order for the Resident to receive a PSA level. According to the lab profiles the test was administered on July 12, 2007. At the time of survey, however, there were no PSA results, available. 4. The GHMRP's nurse failed to obtain Dilantin	I 395	1395 * Reference response to W322, W336, W331, W96 * Also reference response to W436	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 14 and Phenobarbital levels as ordered by the physician as evidenced by the following: Resident #2 was observed receiving Dilantin 150 mg and Phenobarbital 90 mg on October 2, 2007, at 6:35 PM. Review of the Resident' s neurology consultations revealed that she was seen on August 2, 2007. The Neurologist recommended obtaining monthly Dilantin and Phenobarbital levels, complete metabolic panels, and complete blood count with differentials twice per year. The Resident was to return to his office with all lab results in two months. A physician order reflecting the recommendations was noted in the record. Review of the laboratory reports failed to evidence that a Phenobarbital and Dilantin level was obtained in August 2007, however one was obtained September 2007. Interview with the GHMRP ' s nurse on October 4, 2007 revealed that blood levels should have been drawn in August as ordered. 5. The GHMRP failed to obtain a swallowing study for Resident #4. Observations during the meals throughout the survey from October 2 - 5, 2007 revealed that Resident #4 was served a pureed diet. Review of the Resident #4's medical record revealed a physician order dated June 19, 2007, for a swallow study. Further review of the records revealed that the study had been scheduled for December 18, 2007, 6 months after the order. 6. Observations on October 2, 2007 at approximately 7:30 PM, Resident #4 was observed wearing adult protective undergarments. Interview with the direct care staff indicated that the Resident wears diapers.	I 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 15 Review of the Resident's nursing notes on October 4, 2007 at approximately 11:00 AM revealed that the Resident had a urology consult on July 26, 2007 and should return in one year. However, there was no medical consultation sheet to confirm that the appointment had been completed. 7. The GHMRP's nurse failed to ensure that Resident #2's health status was reviewed by the Registered Nurse on a quarterly or more frequent basis. [See W336]	I 395	(7.) Reference response to W336 Federal deficiency report.	
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for current licenses for all consultants. The finding includes: Review of personnel records on October 4, 2007 at 8:15 AM revealed the professional license for the facility's occupational therapist was expired.	I 396	1396 3520.2 (f) This Statute will be met as evidenced by Professional license for occupational therapist has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 396	Continued From page 16 The QMRP was informed of the lack of current license for the aforementioned professionals in accordance with the Health Occupation Revision Act (HORA), Title 3 Chapter 12, Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	I 396	been obtained. @ Administrative Assistant will continue to track and monitor expiration dates and provide follow-up as needed to ensure ongoing compliance with this standard.	11.6.07
I 398	3520.2(h) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (h) Social Work; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for current licenses for all consultants. The finding includes: Review of personnel records on October 4, 2007 at 8:15 AM revealed the professional license for the facility's social worker was expired. The QMRP was informed of the lack of current license for the aforementioned professionals in accordance with the Health Occupation Revision Act (HORA), Title 3 Chapter 12, Section 3-1205.13 ("Each licensee shall display the	I 398	1398 3520.2 (A) This Statute will be met as evidenced by: Reference response to 3520.2 (F) licenses and health certificates	11.6.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 398	Continued From page 17 license conspicuously in any and all places of business or employment of the licensee.")	I 398		
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents were effectively trained in tooth brushing. The finding includes: Review of Resident #3's medical record revealed a dental consultation dated June 6, 2007. The consultation indicated that the client had heavy calculus deposits and poor oral hygiene. Review of the IPP dated April 25, 2007 failed to identified a toothbrushing program.	I 432	1432 (c.) QMRP will provide additional staff training in area of bathing shampooing, brushing teeth and menstrual care. This Statute will be met as evidenced by: • QMRP will develop toothbrushing program for client #3. • QMRP will ensure that IPP reflects current goals and objectives.	11.14.07 ongoing.
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as	I 437	1437 3521.7(g)	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 18 books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide habilitation and training for two of the four residents included in the sample. (Residents #3 and #4) The findings include: 1. On October 3, 2007 Resident #4's home activities from 8:00 AM to 1:30 PM were observed and revealed the following: a) Upon the surveyors arrived to the home at 8:00 AM Resident #4 was observed at the kitchen table preparing to eat his breakfast. The resident was served his breakfast and did not participate in the meal time preparation or service. Although the resident was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. b) At approximately 8:30, after completing his breakfast, the resident was taken to his bedroom where he remained until lunchtime. The resident was periodically observed in his bedroom lying on his bed without any without constructive/habilitative activities. c) At approximately 12:00 PM, the resident was escorted in his wheelchair to the living room and positioned in front of the television. d) During lunch, at approximately 12:30 PM, Resident #4 was observed exhibiting face slapping behaviors. The direct care staff	I 437	This Statute will be met as evidenced by: * Reference response to federal deficiency report W250, W260, & W196.	11.14.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 19 intervened by stating "Oh, no we won't have that". The resident ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Resident's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the resident to stop. If the resident did not stop, the staff was required to move the resident's hand down from his face and continue with proactive strategies. e) After lunch, at approximately 1:30 PM, direct care staff took the resident on a van ride. 2. Interview with staff on October 2, 2007 revealed that Resident #4 dependents on staff for basic personal needs On October 2, 2007, the resident was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the resident with his jacket. The staff confirmed that the resident needs assistance with bathing, dressing and toileting. Review of the resident's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the resident's personal care skills had been identified/assessed. 3. Review of Resident #4's IPP revealed that recommended training programs were not consistently implemented as evidenced below: Review of the Resident #4's IPP revealed objectives to enhance sensory awareness, to improve lower range of motion and strengthen	I 437		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 20 lower extremities, and to improve ambulation and auditory skills. At no time during the observations did the staff direct encourage, the resident' to participate in any of the aforementioned program objectives as evidenced below: 'a) Three times per week, the resident' will feel/manipulate items in his feel box for three minutes with hand over hand assistance for six consecutive months by 10/07. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007 revealed that there was no box available with such items. Review of the data, however, revealed that the program was being implemented and that the client had achieved the required objective, since April. The facility QMRP could not explain how the program was being implemented without the box. 2. The facility failed to implement Resident #3's program objectives. a) Interview with the QMRP on October 2, 2007 at 9:40 AM indicated the Resident #3 was admitted to the facility on March 26, 2007. During evening observation on October 2, 2007 from 3:45 PM through 6:55 PM, Resident #3 was not engaged in any formal or informal active treatment programs. At 3:30 PM, the client arrived home from his day program and shortly thereafter, at approximately 3:45 PM, was taken to his bedroom. He was observed to lie in bed until 6:55 PM. The resident was observed to need total assistance in transferring from his wheelchair to and from bed.	I 437		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 21 At 6:55 PM, the resident was propelled into the living room and positioned in front of the television, where he remained until he received his G-tube feeding at 8:00 PM. There was no observation that the staff presented the resident with a choice of leisure time activities or engaged the resident in any other activity. b) Review of Resident #3's IPP dated April 25, 2007 revealed an objective that the client will sit on the edge of the bed for two minutes three times a day without assistance for three months. There was no observations of the resident participating in this activity. According to the data sheets since June 2007 the direct care staff were documenting only twice a day. c) Review of Resident #3's IPP dated April 25, 2007 revealed an objective that the resident will tolerate stretching to his lower extremities daily for two minutes each stretch for six months. There was no observations of the resident participating in this activity. According to the data sheets since June 2007 the direct care staff were not documenting the number of minutes. d) Review of resident's IPP dated April 25, 2007 revealed an objective which stated, "Five days a week, given hand over hand assistance, [the resident] will make a selection of what clothes to wear daily in 80% of the trials presented for six consecutive months by April 2008." On October 2, 2007 at 3:45 PM, a pair of jeans and shirt was observed on Resident #3's nightstand. Interview with the direct care staff at 6:00 PM indicated that the clothes were selected	I 437		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 437	Continued From page 22 by the staff for the resident to wear on the next day. There was no evidence that the facility encourage the resident to participate in this task. 3. During the evening meal observation on October 2, 2007, Resident #1 ate her meal with minimal to no assistance from staff. Upon the completion of the meal, the staff who was assisting the client with her meal, passed the dish and eating utensils to another staff person who was located in the kitchen. Review of the resident IPP objective on October 4, 2007, revealed that the resident had a goal to increase her activities of daily living skills. To accomplish this goal, the resident was required ". . . after dinner meal, given physical assistance, [Resident Name] will remove her plate to the kitchen on 100% of the trials presented for six consecutive months." On October 2, 2007, Resident #1 was not afforded an opportunity to participate in this IPP goal.	I 437		
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure the habilitation of its residents included training in the area of mobility for one of the four residents in the facility. (Resident #3) . The finding includes:	I 441	1441 3521.7 (K) This Statute will be met as evidenced by;	

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 23 On October 3, 2007, Resident #4's home activities from 8:00 AM to 1:30 PM were observed and revealed the following: a) Upon the surveyors arrived to the home at 8:00 AM Resident #4 was observed at the kitchen table preparing to eat his breakfast. The client was served his breakfast and did not participate in the meal time preparation or service. Although the client was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. b) At appoximately 8:30, after completing his breakfast, the client was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitative activities. c) At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. d) During lunch, at approximately 12:30 PM, Resident #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The client ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Client's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to ask the client to stop. If the client did not stop, the staff was required to move the client's hand down from his face and continue with proactive strategies. e) After lunch, at approximately 1:30 PM, direct care staff took the client on a van ride.	I 441	1441 Reference response to Federal dificiency report, W196, W250, W252, W210, W224 W102, W120, W193 of federal deficiency report.	11.18.07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 24 2. Interview with staff on October 2, 2007 revealed that Resident #4 dependents on staff for basic personal needs On October 2, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of October 2, 2007, the staff was observed assisting the client with his jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on October 4, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to review that the client's personal care skills had been identified/assessed. 3. Review of Resident #4's IPP revealed that recommended training programs were not consistently implemented as evidenced below: Review of the Resident #4's IPP revealed objectives to enhance sensory awareness, to improve lower range of motion and strengthen lower extremities, and to improve ambulation and auditory skills. At no time during the observations did the staff direct encourage, the client to participate in any of the aforementioned program objectives as evidenced below: a) Three times per week, the client will feel/manipulate items in his feel box for three minutes with hand over hand assistance for six consecutive months by 10/07. Interview with the Qualified Mental Retardation Professional (QMRP) on October 4, 2007	I 441		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 25 revealed that there was no box available with such items. Review of the data, however, revealed that the program was being implemented and that the client had acheived the required objective, since April. The facility QMRP could not explain how the program was being implemented without the box. b) [The client] will dance with staff for three minutes two times per day 100% accuracy for six months. Although the data collection refect that this program had been implemented in the past, there was no evidence that the program had been implemented during the survey period. Additionally, the data collected did not measure the progress of the objective. [Also See W252] d) [The client] will ambulate one trip around the interior of the home two times a day with moderate physical assistance of one person at 100% accuracy for six months". Although the October 2007 data collection refected that this program was being implemented one time a day, this program was not observed during the survey period. 2. The facility failed to implement Resident #3's program objectives. a) Interview with the QMRP on October 2, 2007 at 9:40 AM indicated the Resident #3 was admitted to the facility on March 26, 2007. During evening observation on October 2, 2007 from 3:45 through 6:55 PM, Resident #3 was not engaged in any formal or informal active	I 441	Reference response to W252 Federal Deficiency Report.	

PRINTED. 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 441	Continued From page 26 treatment programs. At 3:30 PM, the client arrived home from his day program and shortly thereafter, at approximately 3:45 PM, was taken to his bedroom. He was observed to lie in bed until 6:55 PM. The client was observed to need total assistance in transferring from his wheelchair to and from bed. At 6:55 PM, the client was propelled into the living room and positioned in front of the television, where he remained until he received his G-tube feeding at 6:00 PM. There was no observation that the staff presented the client with a choice of leisure time activities or engaged the client in any other activty. b) Review of Resident #3's IPP dated April 25, 2007 revealed an objective that the client will sit on the edge of the bed for two minutes three times a day without assistance for three months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were documenting only twice a day. c) Review of Resident #3's IPP dated April 25, 2007 revealed an objective that the client will tolerate stretching to his lower extremities daily for two minutes each stretch for six months. There was no observations of the client participating in this activity. According to the data sheets since June 2007 the direct care staff were not documenting the number of minutes.	I 441	Reference response to W196	11.14.07 ongoing
I 458	3521.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be	I 458		

PRINTED 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 458	Continued From page 27 available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's activity schedule was up to date and current for direct care staff implementation. The finding includes: Upon the surveyors arrived to the home at 8:00 AM, Resident #4 was observed at the kitchen table preparing to eat his breakfast. The resident was served his breakfast and did not participate in the meal time preparation or service. Although the resident was independent in feeding himself, staff used hand over hand assistance to encourage him to complete his meal. At approximately 8:30, after completing his breakfast, the resident was taken to his bedroom where he remained until lunchtime. The client was periodically observed in his bedroom lying on his bed without any without constructive/habilitation activities. At approximately 12:00 PM, the client was escorted in his wheelchair to the living room and positioned in front of the television. At 12:30 During lunch, at approximately 12:30 PM, Resident #4 was observed exhibiting face slapping behaviors. The direct care staff intervened by stating "Oh, no we won't have that". The resident ceased the behavior momentarily. The staff did provide any further redirection/intervention. According to the Resident's current Behavior Support Plan, reviewed on October 3, 2007, required the staff to	I 458	Reference response to W196	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
101	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 458	Continued From page 28 ask the client to stop. If the resident did not stop, the staff was required to move the resident's hand down from his face and continue with proactive strategies. After lunch, at approximately 1:30 PM, direct care staff took the resident on a van ride. Interview with the direct care staff and review of the habilitation record revealed that the resident had no activity schedule for that day, and no record of an alterative activity schedule.	I 458	1458	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure the residents were protectioned from injuries of unknown origin for foru of the eight clients residing in the facility. (Residents #2, #3, #6, and #7) The finding includes: Review of the incident reports on October 2, 2007 beginning at 8:20 AM revealed the following incidents had not been reported to the State Agency as required: a. On April 17, 2007, staff discovered Residentt #2 with a three centimeter discoloration on her left thigh.	I 500	Residents Rights 1500 3523.1 This Statute will be met as evidenced by: Reference response to W153, W159. of federal Deficiency report,	11.13.07 ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 29 b. On September 11, 2007, the staff discovered a "mark" on Resident #3's left back arm. c. On July 16, 2007, the staff discovered a scratch on Resident #3's right back leg. d. On July 9, 2007, the staff discovered an abrasion on Resident #3's left lower leg. e. On June 24, 2007, the staff discovered a bruise on Resident #6's right elbow. f. On June 18, 2007, the staff discovered a blister on Resident #7's right knee.	I 500		

RECEIVED 11/13/07

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (d) Nutrition; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have evidence that it employed a qualified dietician to meet the Resident's needs for two of the five cleints in the sample. (Resident's #1 and #5) The finding includes: 1. Resident #1's record was reviewed on October 3, 2007. The Resident had a nutritional assessment on August 31, 2006. Review of the Residents weight records revealed that she had lost 9 pounds (lbs) from March to April 2007, and continued to gradually lose weight. The last record weight was in October 2007 and the Resident weight 92 lbs. It was noted, however that she remained within her ideal body weight of 85 - 110 lbs. Further review of the record failed to show evidence that the Resident's nutritional status had not been monitored by a dietician quarterly (1st quarter September 2006, October 2006, and November 2006, and 2nd quarter December 2006, January2007, and February	I 394	Reference response W322, W331 and W336.	10.18.07 ongoing

Health Regulation Administration

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE DRS — (X6) DATE 11/9/07

STATE FORM 6899 DWO411 If continuation sheet 1 of 6

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 394	Continued From page 1 2007)as required. [See Also W322] 2. According to a nutritional assessment dated August 31, 2006, Resident #5 had an ideal body weight (IBW) of 93 - 122 pounds. Review of the Resident ' s weight charts revealed that although Resident #5 had an 8.5 lbs decrease in weight from March 2007, to August 2007; she remains well within her ideal body weight. Further review of the record lacked evidence that the Resident's nutritional status had been monitored by a dietician quarterly (1st quarter September 2006, October 2006, and November 2006, and 3rd quarter March 2007, April 2007, and May 2007)as required. The nutritionist was in the GHMRP on October 2, 2007. In an interview conducted on October 3, 2007, she indicated that she had taken a year off and was not aware that the GHMRP was without a reliable dietician in her absence. She indicated that the provider had re-hired her and that she had completed nutritional assessment on all of the Residents on October 2, 2007. Review of the records verified that the nutritionist completed all necessary assessments which were dated October 2, 2007. Interview with the GHMRP's Administrator on October 4, 2007 revealed that the GHMRP current dietician who was re-hire was "very reliable." However, due to her subbatical, the provider contracted with another dietician, who was not providing the nutritional oversight as required in his/her contracted.	I 394	@ Also reference response to W455	
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified	I 395	3520.2 (e)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 2 professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the GHMRP failed to ensure nursing services in accordance with the needs of three of four Residents in the sample. (Residents #2, #3 and #4) The findings include: 1. The GHMRP's LPN failed to follow Resident #3's physician order that required the nurse to give pleasure feeding 15 minutes after regular scheduled feeding. On October 3, 2007 at 10:35 AM, the Licensed Practical Nurse (LPN) was observed feeding Resident #3 through his G-tube. The G-tube feeding ended at 11:05 AM. At 11:08 AM, the LPN was observed feeding the Resident his pleasure feeding of cranberry juice. Interview with the LPN indicated that the Resident had been doing well with his pleasure feeding. Review of Resident #3's current physician order required the Resident to receive pleasure feedings 15 minutes after each schedule G-Tub feeding (11:00 AM, 4:00 PM and 8:00 PM).	I 395	Continued from page 2 This Statute will be met as evidenced by: Reference response to federal deficiency report W322, W331 and W336,	10-18-07 ongoing

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 3 Further interview with the Registered Nurse on October 3, 2007 at approximately 2:00 PM revealed that the Resident should wait the required 15 minutes to ensure that his stomach was "not overloaded with liquids." 2. The GHMRP's nurse failed to schedule medical consultation appointments for Resident #3, timely. a. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Resident #3 was admitted to the GHMRP on March 26, 2007. October 2 - 5, 2007 the Resident was observed in a wheelchair. Review of Resident's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the Resident be fitted for a knee brace. b. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2007 at 9:40 AM, revealed that Resident #3 was admitted to the GHMRP on March 26, 2007. Observations during the survey from October 2 - 5, 2007, the Resident was observed in a wheelchair with tight limbs. Review of Resident's clinical record revealed a Physical Therapy assessment dated April 24, 2007. The assessment recommended that the Resident receive an evaluation at a spasticity clinic. 3. The GHMRP's nurse failed to obtain PSA lab results for Resident #4. Review of Resident #4's medical record revealed a physician order for the Resident to receive a PSA level. According to the lab profiles the test was administered on July 12, 2007. At the time of survey, however, there were no PSA results,	I 395	Also reference response to W210, W196, W220 W224, W241, W242 W247 & W249.	11.14.07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 4 available. 4. The GHMRP's nurse failed to obtain Dilantin and Phenobarbital levels as ordered by the physician as evidenced by the following: Resident #2 was observed receiving Dilantin 150 mg and Phenobarbital 90 mg on October 2, 2007, at 6:35 PM. Review of the Resident' s neurology consultations revealed that she was seen on August 2, 2007. The Neurologist recommended obtaining monthly Dilantin and Phenobarbital levels, complete metabolic panels, and complete blood count with differentials twice per year. The Resident was to return to his office with all lab results in two months. A physician order reflecting the recommendations was noted in the record. Review of the laboratory reports failed to evidence that a Phenobarbital and Dilantin level was obtained in August 2007, however one was obtained September 2007. Interview with the GHMRP ' s nurse on October 4, 2007 revealed that blood levels should have been drawn in August as ordered. 5. The GHMRP failed to obtain a swallowing study for Resident #4. Observations during the meals throughout the survey from October 2 - 5, 2007 revealed that Resident #4 was served a pureed diet. Review of the Resident #4's medical record revealed a physician order dated June 19, 2007, for a swallow study. Further review of the records revealed that the study had been scheduled for December 18, 2007, 6 months after the order. 6. Observations on October 2, 2007 at approximately 7:30 PM, Resident #4 was	I 395		

PRINTED: 10/22/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 5 observed wearing adult protective undergarments. Interview with the direct care staff indicated that the Resident wears diapers. Review of the Resident's nursing notes on October 4, 2007 at approximately 11:00 AM revealed that the Resident had a urology consult on July 26, 2007 and should return in one year. However, there was no medical consultation sheet to confirm that the appointment had been completed. 7. The GHMRP's nurse failed to ensure that Resident #2's health status was reviewed by the Registered Nurse on a quarterly or more frequent basis. [See W336]	I 395	Reference response to W336	11.14.07 ongoing.